Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

Q THAI NGUYEN DC
4151 SW FWY #210
HOUSTON TX 77027

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
SENTRY INSURANCE A MUTUAL CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-11-0728-01

MFDR Date Received
NOVEMBER 8, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient denied by insurance compan7 stating claim closed and peer review on file, peer review appealed on a timely manner, attached letters ,denied [sic] payment for medical bills, attached medical notes eob's hicfa's , dwc 60 with additional medical documentation"

Amount in Dispute: $2,923.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated December 6, 2010: "The medical dispute concerns reimbursement for medical treatment the requestor provided to the claimant between March 18, 2010 and May 11, 2010. The carrier has denied reimbursement on the bases that the treatment offered was not medically necessary. The requestor believes that the treatment was pre-authorized. The carrier submits that the March 18, 2010 date of service was not pre-authorized. The carrier will re-audit the medical bills for the remaining dates of service, and tender whatever reimbursement amounts are deemed appropriate to the provider."

Respondent's Supplemental Response dated December 8, 2010: Carrier has previously responded to this dispute on December 6, 2010. The Carrier has gone back and re-audited the disputed medical bills, and determined that the requestor is entitled to $2511.65 in reimbursement. This amount will be tendered to the requestor."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 14, 2010 April 19, 2010 April 20, 2010 April 21, 2010 April 26, 2010 April 27, 2010 April 28, 2010 May 3, 2010 May 4, 2010 May 5, 2010	CPT Code 99211 – 12 Dates of Service	$336.00	$60.00

May10, 2010 May 11, 2010			
April 14, 2010 April 19, 2010 April 20, 2010 April 21, 2010 April 26, 2010 April 27, 2010 April 28, 2010 May 3, 2010 May 4, 2010 May 5, 2010 May10, 2010 May 11, 2010	CPT Code 97112 – 2 Units per Session x 12 Sessions = 24 Units	$891.84	$123.84
April 14, 2010 April 19, 2010 April 20, 2010 April 21, 2010 April 26, 2010 April 27, 2010 April 28, 2010 May 3, 2010 May 4, 2010 May 5, 2010 May10, 2010 May 11, 2010	CPT Code 97110 – 3 Units per Session x 12 Sessions = 36 Units	$1,296.00	$216.00
April 14, 2010 April 19, 2010 April 20, 2010 April 21, 2010 April 26, 2010 April 27, 2010 April 28, 2010 May 3, 2010 May 4, 2010 May 5, 2010 May10, 2010 May 11, 2010	CPT Code 97140 – 1 Unit per Session x 12 Sessions = as Units	$399.96	$51.96
March 18, 2010	CPT Code 99080-73	$15.00	$0.00
March 18, 2010	CPT Code 99204 and HCPCS Code E0215	$247.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional services.
3. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
4. 28 Texas Administrative Code §133.308 sets out the procedures for requesting an Independent Review Organization (IRO).
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 29, 2010, June 21, 2010 and December 5, 2010
   - 1 (216) – Based on the findings of a review organization.
   - 1 – Unnecessary medical treatment and or service peer review; documentation attached.
   - * - Denied per adjuster.
   - 1 (45) – Charges exceed your contracted/legislated fee arrangement.

- 2 (W1) – Workers Compensation State Fee Schedule Adjustment
- 1 – This contracted provider or hospital has agreed to reduce this charge for your business.
- 2 – This bill was reviewed in accordance with your FOCUS contract.

Issues

1. Did either party support that a contract exists between the parties?
2. Was the [issue 2 *** Tip: write the findings first and then come back here and write the questions that correspond to each numbered finding. The last sentence of each finding should answer the question asked in the issue here.]?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Charges exceed your contracted/legislated fee arrangement"; 2 (W1) – "Workers Compensation State Fee Schedule Adjustment" and 2 – "This bill was reviewed in accordance with your FOCUS contract." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on November 8, 2010. Included on the Table of Disputed Services were CPT Code 99204 and HCPCS Code E0215 which were denied for unnecessary medical treatment and or service peer review. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) goes on to state that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." 28 Texas Administrative Code §133.307(e)(3)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of medical necessity have been resolved as of the undersigned date.
3. On March 18, 2010 the requestor billed CPT Code 99080-73 – Work Status Report. The Work Status Report is considered a Division ordered report and not subject to a medical necessity denial. In accordance with 28 Texas Administrative Code §129.5 (b)The doctor shall file a Work Status Report in the form and manner prescribed by the Commission and (d)The doctor shall file the Work Status Report: (1)after the initial examination of the employee, regardless of the employee's work status. Review of the submitted documentation by the requestor does not contain a completed DWC-73. As a result the amount ordered is $0.00.
4. The respondent initially denied the office visits and physical therapy treatment as "unnecessary medical treatment and or service peer review." The requestor submitted a Request for Medical Fee Dispute Resolution and included a copy of the preauthorization approval for "PT x 12 to lumbar 97110(3), 97112(2) and 97140(1). On December 7, 2010 the respondent re-audited and reimbursed the requestor a total of $2,472.00 plus $39.65 in interest. Review of the requestor's CMS-1500 and the Table of Disputed Service the requestor billed at a lower reimbursement amount that the maximum reimbursement allowed in accordance with 28 Texas Administrative Code §134.203(b) and (c). Listed below are CPT Codes with total amount billed, insurance carrier reimbursement amount and amount due to requestor:
    - CPT Code 99211 – Requestor billed 12 dates of service at $28.00 per day for a total amount of $336.00; the insurance carrier reimbursed at $23.00 per date of service for a total of $276.00. As a result the amount ordered is $60.00.
    - CPT Code 97112 – Requestor billed 2 units per session for 12 days for a total amount of $891.84; the insurance carrier reimbursed at $74.32 per 2 units per date of service for a total of $768.00. As a result the amount ordered is $123.84.
    - CPT Code 97110 – Requestor billed 3 units per session for 12 days for a total amount of $1,296.00;

the insurance carrier reimbursed at $90.00 per 3 units per date of service for a total of $1,080.00. As a result the amount ordered is $216.00.

- CPT Code 97140 – Requestor billed 1 unit per session for 12 days for a total amount of $399.96; the insurance carrier reimbursed at $29.00 per unit per session for 12 days for a total amount of $348.00. As a result the amount ordered is $51.96.

5. Review of the submitted documentation finds the treatment/services were rendered as billed.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $451.80.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $451.80 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		February 21, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.